LifeWise Health Plan of Washington	Payment Policy

cmi_137079

Title	**Consultation Code Services**		
Number	**CP.PP.377.v2.1**		
Last Approval Date	04/11/24	Original Effective Date	10/07/12
Cross Reference			

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose

To define the Plan's limitations for consultation code services that are submitted on a CMS-1500 paper claim form or an 837P electronic claim form.

Scope

Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.

Policy

Consultation codes, both inpatient and outpatient, are eligible for reimbursement only when billed by providers contracted on a 2009 or earlier Resource Based Relative Value System (RBRVS) fee agreement. Consultation codes submitted by all other providers are not eligible for reimbursement.

Consultation services previously reported with one of the consultation codes must be reported with an appropriate Evaluation and Management (E&M) procedure code, such as but not limited to, an office visit code, hospital care code, nursing facility care code or a home visit code in order to be considered for reimbursement.

Codes/Coding Guidelines

For the purpose of this policy, the consultation codes that are not separately reimbursable include the following:

Inpatient and Outpatient Consultations:

Outpatient:

- **99242 -** Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- **99243** - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- **99244** - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- **99245** - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

	Inpatient: • **99252 -** Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded. • **99253** - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. • **99254** - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. • **99255** - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	<u>For contracted Alaska providers</u>: Consultation code charges for dates of service prior to December 11, 2023, will be eligible for reimbursement. Consultation code charges for dates of service on or after December 11, 2023, will be subject to the policy criteria. All other providers are subject to the policy criteria.
Laws, Regulations & Standards	
References	• Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) • American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • American Medical Association's Relative Value Scale Update Committee (AMA RUC)

Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.
Annual Review Dates	04/11/24; 01/16/24; 08/10/23; 07/07/23; 08/18/22; 09/22/21; 10/06/20; 12/04/19; 12/06/18; 08/19/18; 10/19/17; 10/19/16; 11/15/15; 11/23/14; 12/15/13; 09/12/13; 10/07/12

This policy was published April 16, 2024

Version History	08/09/18	Added new section “Code/Coding Guidelines” to the policy and moved the codes and descriptions to this new section
	12/06/18	Effective with dates of service 01/01/2019 and after, Interprofessional Telephone/Internet Consultation codes are removed from Medicare “Status B” classification (per CMS) and are eligible for reimbursement
	12/04/19	Annual review; no changes
	10/06/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms. Removed references to Interprofessional Telephone/Internet Consultation codes since the codes became reimbursable as of January 1, 2019, and are covered in the Telehealth Services policy. Removed the cross reference to Medicare Status B codes since the Interprofessional Telephone/Internet Consultation codes are no longer classified as Status B codes
	09/22/21	Annual review; no changes
	08/18/22	Codes in Codes/Coding Guidelines and in Policy reflect the January 1, 2023, CPT Code updates/revisions; Codes 99241 and 99251 deleted and code descriptions updated to reflect the revisions effective January 1, 2023.
	07/07/23	Annual review; no changes
	08/10/23	Alaska providers on a 2010 or more current Resource Based Relative Value System (RBRVS) fee schedule are subject to the policy criteria effective with claim dates of service **on and after December 11, 2023.**
	01/16/24	Revised the Policy statement to clarify that the policy already applied to Washington contracted providers and to Alaska contracted providers as of claims dates of service on and after December 11, 2023, as announced in the August 2023 policy version update.
	04/11/24	• Clarified the Policy statement to indicate that consultation codes, both inpatient and outpatient, are eligible for reimbursement only when billed by providers contracted on a 2009 or earlier Resource Based Relative Value System (RBRVS) fee agreement. • Clarified the Exception section for contracted Alaska providers to indicate that consultation codes with dates of service prior to December 11, 2023, will be reimbursed and on or after this date will be subject to the policy criteria. All other providers are subject to the policy.

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