Consultations

A consultation is a type of evaluation and management (E/M) service provided by a physician at the request of another physician to either recommend care for a specific condition or to determine whether to accept responsibility for ongoing management of the recipient's entire care or the care of a specific condition.

Louisiana Medicaid reimburses for a consultation, in either a hospital or outpatient setting when the consultation is:

- Performed by a physician other than the attending/primary care physician,
- Performed at the request of the attending/primary care physician, i.e., the 'requesting physician', and
- Medically necessary, unduplicative, reasonable, and needed for adequate diagnosis and/or treatment.

NOTE: A consultation **is not synonymous with a "referral."** A physician referral of a recipient to another physician should not automatically be considered a consultation. The criteria described above must be met in order for the service to be considered a consultation. **Services provided that do not meet this criteria should not be billed using consultation codes.**

A consultation by a provider of the same specialty as that of the requesting physician will be allowed when circumstances are of an emergent nature as supported by diagnosis, and the requesting physician needs immediate consultation regarding the recipient's condition. Medical Review of the documentation will occur before reimbursement is authorized.

The consulting physician must render a written opinion and/or give advice to the requesting physician regarding the evaluation and/or management of a recipient and may initiate diagnostic services.

The recipient's medical records must be available for review, and the documentation therein must substantiate the need for the consultation. Both physicians' records for the recipient should be reflective of:

- The request for the consultation,
- The consultant's opinion, and
- Any services that were ordered or performed and communicated by written report to the requesting physician.

Confirmatory consultations and consultations for recipients with simple diagnoses or who require non-complex care are not covered.

Consultations are included in the outpatient visit limits for recipients age 21 and older.

Consultations are subject to national coding standards.

Billing for Consultations

The criteria detailed above should be used to determine if a consultation code may be billed.

If by the end of the service the consulting physician determines and documents in the recipient's record that the recipient does not warrant further treatment by the consultant, the consultation code may be billed.

If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the recipient's condition(s), the appropriate E/M services code for the site of service should be reported. If the recipient returns at a later date for treatment, the subsequent visit(s) should be billed using the appropriate level E/M service code for the site of service.

If the surgeon's role is assumed by the consultant, those services are subject to Pre and Post Operative editing, as those edits would supersede this policy.

The consulting physician should not have served as the primary care or concurrent care provider within 730 days prior to performing the consultation.

Claims for consultations should indicate the name and National Provider Identifier (NPI) of the requesting physician on Item 17 on the CMS 1500 or the NPI of the requesting physician in the 2310A loop on the 837P, which should be different from that of the consulting physician.

All claims are subject to post-payment review and the recipient's medical records must substantiate the billing of consultations.

NOTE: Inpatient and outpatient consultation policy does not apply to state-funded foster children (aid category 15).