Consultation Services Policy

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, clinical rationale, industry standard reimbursement logic, regulatory issues, business issues and other input in developing reimbursement policy may apply.

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. **Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates.** Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

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Applicability

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent and for claims submitted online through the provider portals.This policy applies to Commercial, Medicare, all Individual Exchange benefit plans, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

This policy addresses the information Optum requires to be submitted with reimbursable consultation services codes and how services rendered at the request of another physician or appropriate source may be reported in lieu of CPT(®) consultation services codes 99242-99245 and 99252-99255.

Reimbursement Guidelines

Prior Optum reimbursed consultation services in alignment with the consultation services coding guidelines published within the American Medical Association (AMA) Current Procedural Terminology (CPT ®) book. That description states a consultation is a type of evaluation and management service provided at the request of another physician 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.

For dates of service prior to 3/1/2020, Optum will reimburse consultation services in alignment with the consultation services coding guidelines published within the American Medical Association (AMA) Current Procedural Terminology (CPT ®) book. That description states a consultation is a type of evaluation and management service provided at the request of another physician 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.

Effective for claims with dates of service on or after 3/1/2020, Optum aligns with the Centers for Medicare and Medicaid Services (CMS) and does not reimburse consultation services procedure codes 99242-99245, 99252-99255, including when performed via telehealth. The codes eligible for reimbursement are those that identify the appropriate Evaluation and Management(E/M) procedure code which describes the office visit, hospital care, nursing facility care, home service or domiciliary/rest home care service provided to the patient.

Optum aligns with CMS and considers interprofessional consultation codes 99451, 99446-99449 for reimbursement. If the following documentation guidelines are met:

- can be reported for new or established patients
- can be reported for a new or exacerbated problem
- are reported only by a consultant when requested by another physician/QHP
- cannot be reported more than once per 7 days should include cumulative billing time for the same patient
- are reported based on cumulative time spent, even if that time occurs on subsequent days
- are not reported if a transfer of care or request for a face-to-face consult occurs as a result of the consultation within the next 14 days
- are not reported if the patient was seen by the consultant within the past 14 days
- require that the request and the reason for the request for the consult be documented in the record
- require verbal consent for the interprofessional consultation from the patient/family documented in the patient’s medical record

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The requesting physician or other appropriate source must be identified on the claim. If the requesting entity is not identified on the claim, the consultation service will be denied because it does not meet requirements for reporting such a code.

Optum aligns with CMS and considers interprofessional consultation code 99452 for reimbursement.
If the following documentation guidelines are met:

Requesting/treating physician/QHP code 99452:

- is reported by the physician/QHP who is treating the patient and requesting the non-face-to-face consult for medical advice or opinion — and not for a transfer of care or a face-to-face consult
- is reported only when the patient is not on-site and with the physician/QHP at the time of the consultation
- cannot be reported more than once per 14 days per patient
- includes time preparing for the referral and/or communicating with the consultant
- requires a minimum of 16 minutes
- can be reported with prolonged services, non-direct

Optum will not reimburse for CPT Code 99451, and 99446-99449 if the following 2 situations occur:

- If an in-person visit with the psychiatric consultant has occurred within the previous 14 days or will occur within the next 14 days.
- If the sole purpose of the contact is to transfer care or arrange for an in-person consultation with the psychiatric consultant
- Do not bill CPT code 99451 for services less than 5 minutes

99452 is to be used by physician requesting the consult if 16-30 min of time is used preparing the referral and/or communicating with the psychiatric consultant. Cannot be reported more than once in a 14-day period per patient

Codes		
CPT Code	**Description**	**Time Spent**
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, **5 minutes** or more of medical consultative time	5 minutes or more
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	30 minutes
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified	5-10 minutes

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	health care professional; **5-10** minutes of medical consultative discussion and review	
99447 99448 99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physicia1n or other qualified health care professional; **11-20** minutes of medical consultative discussion and review Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	11-20 minutes 21-30 minutes 31 minutes or more

Questions and Answers	
1	**Q:** What happens after March 1, 2020 if the care provider's claim for service is denied? **A:** When consultation services codes 99242-99245 and/or 99252-99255 are denied for dates of service on or after 3/1/2020, care providers should submit an appropriate E/M service in alignment with either the 1995 or 1997 E/M Coding Guidelines.
2	**Q:** Which consultation services codes will continue to be reimbursable? **A:** Telehealth Consultation services that reflect Interprofessional consultations represented by procedure codes 99451, 99452, 99446-99449 will be eligible for reimbursement if reported with the referring entity's name and/or National Provider Identifier (NPI) number. This information should be reported in field 17 or 17b on the CMS 1500 form or its electronic equivalent.
3	**Q**. What documentation and patient information is required in order to be reimbursement for consultation services?

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	A. CPT codes 99446-99449, written documentation can include date of call; patient name, insurance information and date of birth; brief statement of the problem; pertinent physical exam findings reported by the requesting/treating physician/QHP; labs/X-ray findings; differential diagnosis (if applicable) and focused recommendations. Billing for interprofessional services is limited to practitioners who can independently bill Medicare for E/M services.

Resources
American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services American Psychiatric Association American Academy of Pediatrics

History	
November, 2024	Updated Applicability Section & Reimbursement Guidelines Section; Added CPT code 99452
September, 2024	Anniversary review; No updates
September, 2023	Anniversary review; No updates
March, 2023	Updated Reimbursement Guidelines Section as it relates to 99451 and 99446-99449 added Q&A 2 &3
January, 2023	Removed deleted codes 99241and 99251 effective 1/1/2023
September, 2022	Anniversary review; No updates
September, 2021	Anniversary review; No Updates
September, 2020	Anniversary review
September, 2019	New policy

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