

TRANSMITTAL #: 77  
DATE: 09/16/2004  
TRICARE CHANGE #: N/A

## CHAMPVA POLICY MANUAL

CHAPTER: 2  
SECTION: 15.7  
TITLE: CONSULTATIONS

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**AUTHORITY:** 38 CFR 270(a) and 38 CFR 17.272(a)

**RELATED AUTHORITY:** 32 CFR 199.4 (c)(2)(vi)

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### I. EFFECTIVE DATE

January 1, 1992

### II. PROCEDURE CODE(S)

A. **CPT codes:** 99241-99275

B. **HCPCS Level II codes:** G0179, G0180-G0181

### III. DESCRIPTION

A consultation is a type of service provided by an authorized provider whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another authorized provider. The attending physician's request and the need for consultation must be provided for the patient's permanent medical record. The consultant's opinion, along with any services that were ordered or performed, must also be documented in the patient's record and communicated to the requesting provider.

### IV. POLICY

A. Consultations performed by an authorized individual professional provider at the request of the patient's attending provider are covered.

B. The four subcategories of consultation are:

1. office,
2. inpatient,
3. follow-up inpatient, and

4. confirmatory.

C. The level of services provided within each of these subcategories is based on the following factors:

1. history,
2. examination,
3. medical decision making,
4. counseling,
5. coordination of services,
6. nature of presenting problem, and
7. time.

D. Payment for initial consultations may be made when billed with a surgical procedure performed on the same date of service.

E. Reimbursement for a consultation does not include diagnostic procedures performed by the consultant. Appropriate allowances should be made for such services in addition to the consultation.

## **V. POLICY CONSIDERATIONS**

A. Only one initial or confirmatory consultation is covered when provided by the same provider during the course of the patient's illness (i.e., for the same diagnosis, or episode of illness). More than one initial or confirmatory consultation for the same patient for the same course of illness will be denied as not covered. Providers will be monitored on a post-payment review to determine whether they are submitting a substantial number of the initial or confirmatory consultation codes. Such billing practices constitute fraud and/or abuse.

B. Consultations by providers of the same or different specialties are covered when required because of a complex medical condition. If there is any doubt about the medical necessity for one or more of the services, consultation reports should be obtained and referred for medical review.

C. A copy of the consultation report is not routinely required, although the Health Administration Center may request the report at any time.

D. The name and address of the attending provider is required on each claim for a consultation. Providers are to be advised that if the information is not submitted on the claim, the consultation will be reimbursed only up to the allowable charge.

E. Consultations will be cost shared according to the status of the patient, inpatient or outpatient, at the time the service is rendered.

F. If a consultant assumes responsibility for management of a portion or all of the patient's condition(s), appropriate hospital or office setting CPT procedure codes will be used in lieu of the consultation codes.

G. A consultation performed within three days of a non-diagnostic surgical procedure by the same provider who performed the surgery is included within the surgical fee.

## **VI. EXCLUSIONS**

A. Telephone consultations and telephone toll charges.

B. Staff consultations required by the policies of a hospital or other institution.

C. Routine telephone calls from a physician to a patient or from a patient to a physician.

**\*END OF POLICY\***