Documentation Requirements for Consultation Services Reimbursement Policy					
Policy Number	0062	**Annual Approval Date**	04/2020	**Approved By**	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee

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 code or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding Optum's 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 health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims 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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Application

This policy applies to all products, all network and non-network rehabilitation providers. This includes non-network authorized, and percent of charge contract providers.

Fee schedule/provider contract/client contract may supersede

Policy

Overview

This Policy describes Optum documentation requirements for reimbursement of the Outpatient Consultation CPT codes, 99241-99245.

Reimbursement Guidelines

Documentation Requirements – Outpatient Consultation Services
Optum will align documentation requirements for Outpatient Consultation Services with CPT definition.

Background Information

Outpatient Consultation CPT codes are used to describe services provided by a physician or qualified nonphysician practitioner whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician, qualified nonphysician practitioner, or other appropriate source. Like the E/M CPT codes, Outpatient Consultation CPT codes measure the level of provider work by weighing all pertinent medical findings documented in the history and physical examination sections of medical records in combination with assessments for the complexities and risks of diagnoses and treatments. The documentation requirements embedded within the Outpatient Consultation CPT definitions have proven to be a challenge for practitioners who utilize these codes to report services. This guideline serves to provide clarity and Optum's expectations as they relate to the reporting and documenting of Outpatient Consultation CPT codes.

General Guidelines
Consultations: Office and Outpatient, 99241-99245

Documentation must include evidence of:

- A third-party mandated consultation
- Documentation of a request for a consultation from an appropriate source
- Documentation of the need for consultation in the patient's medical record
- One consultation per consultant
- Provision by a physician or qualified nonphysician practitioner whose advice, opinion, recommendation, suggestion, direction, or counsel is requested for evaluation and treatment recommendations of a patient since that individual's expertise in a specific medical area is beyond the scope of knowledge of the requesting physician or qualified nonphysician practitioner
- Provision of a written report of findings/recommendations from the consultant to the referring physician or qualified nonphysician practitioner

Consultation codes should not be billed repeatedly nor when the consultation is prompted by the patient/family. Consultation codes are used to represent second opinion visits.

If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate ***Evaluation and Management*** services code for the site of service should be reported

In order to report the outpatient consultation codes, criteria must be met with regard to all three components of history, physical examination, and medical decision-making. However, if greater than fifty percent of the consultation is spent in counseling/coordinating care, then the consultant can select a level of service using time as the key factor.

3. **History** (four recognized types of history)
    - problem-focused
    - expanded problem focused
    - detailed
    - comprehensive
2. **Examination** (four recognized types of examination)
    - problem-focused
    - expanded problem-focused
    - detailed
    - comprehensive
3. **Medical decision making** (four recognized types of medical decision-making)
    - straightforward
    - low complexity
    - moderate complexity
    - high complexity
4. Counseling (contributory factor);
5. Coordination of care (contributory factor);
6. Nature of presenting problem (contributory factor); and

7. Time.

DETERMINE AND DOCUMENT THE HISTORY

There are four types of **history** (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history.
To qualify for a given type of history **all three elements in the table must be met**. (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	***Problem Focused***
Brief	Problem Pertinent	N/A	***Expanded Problem Focused***
Extended	Extended	Pertinent	***Detailed***
Extended	Complete	Complete	***Comprehensive***

Chief Complaint (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.

History of Present Illness (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location,
- quality,
- severity,
- duration,
- timing,
- context,
- modifying factors, and
- associated signs and symptoms.

Brief and ***extended*** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

- A ***brief*** HPI consists of one to three elements of the HPI.
- An ***extended*** HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

Review of Symptoms (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For purposes of ROS, the following systems are recognized:

• Constitutional symptoms (e.g., fever, weight loss)
• Eyes
• Ears, Nose, Mouth, Throat
• Cardiovascular
• Respiratory
• Gastrointestinal
• Genitourinary
• Musculoskeletal
• Integumentary (skin and/or breast)
• Neurological
• Psychiatric
• Endocrine
• Hematologic/Lymphatic
• Allergic/Immunologic

- A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI.
- An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.
- A ***complete*** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI *plus* all additional body systems.

Past, Family and/or Social History (PFSH)
The PFSH consists of a review of three areas:
• past history (the patient's past experiences with illnesses, operations, injuries and treatments);
• family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
• social history (an age appropriate review of past and current activities).

- A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.
- A ***complete*** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

DETERMINE AND DOCUMENT THE EXAMINATION
There are four types of examination:
• ***Problem Focused*** – a limited examination of the affected body area or organ system.
• ***Expanded Problem Focused*** – a limited examination of the affected body area or organ system and any symptomatic or related body area(s) or organ system(s).
• ***Detailed*** – an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
• ***Comprehensive*** – a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

DETERMINE AND DOCUMENT THE COMPLEXITY OF MEDICAL DECISION MAKING
There are four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
• The number of possible diagnoses and/or the number of management options that must be considered;
• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
• The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Number of Diagnoses or Management Options
The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Amount and/or Complexity of Data to be Reviewed
The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Risk of Complications and/or Morbidity or Mortality
The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

OTHER: DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE
In the case where counseling and/or coordination of care dominates (more than 50%) of the encounter, documented time is considered the key or controlling factor to qualify for a particular level of Consultation service.

Resources

- American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services

History / Updates

10/07/2010	New
04/2011	Annual review and update
04/2012	Annual review and update
04/2013	Annual review and update
04/2014	Annual review and update

04/2015	Annual review and update
04/2016	Annual review and update
04/2017	Annual review and update
04/2018	Annual review and update
4/2019	Annual review and update
04/2020	Annual review and update