Payment Policy: Physician's Consultation Services

Reference Number: CC.PP.054
Last Review Date: 04/2024

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
To ensure providers bill the correct level of evaluation and management (E&M) CPT® codes when billing for physician's consultation services. Furthermore, to encourage providers to bill consultation services based on 1) where the visit occurred and 2) the complexity of the visit performed.

The purpose of this policy is to define payment criteria for consultation services to be used in making payment decisions and administering benefits.

Application
Physician and other qualified health professionals that perform initial E&M services.

Policy Description
The American Medical Association (AMA) Current Procedural Terminology (CPT ®) book describes a consultation as 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. Consultation codes are found in the 99242-99255 range of the CPT® code book.

In 2006 the Office of Inspector General (OIG) reported that 75 percent of services billed as consultations were improperly paid and did not meet correct coding standards. Specifically, provider documentation did not support that a consultation service had been rendered and in the case where a consultation service was supported by the documentation, many visits were coded at the incorrect type or level of service.

In 2011, the Center for Medicare and Medicaid Services (CMS) eliminated the use of consultation codes for payment of E&M services furnished to fee-for-service Medicare recipients. The services can still be covered if they are medically necessary using the appropriate office visit, emergency office visit and initial hospital services codes.

Reimbursement
The Health Plan will reimburse consultation codes at the corresponding E&M visit level. The provider should bill the E&M code (other than the consultation code) that describes the service provided.

Utilization

The health plan will identify consultation codes 99242-99255 and crosswalk them to the more appropriate level of office visit, initial inpatient visit, or emergency department procedure code. The provider will be paid according to the fee schedule for the equivalent procedure code.

Medicare guidelines on replacement codes for consultation services

Crosswalks for outpatient office and emergency room visits

Consultative Services Code	E/M Codes for Office/Outpatient Consultations	Codes for Emergency Department Consultations not requiring admission of patient into inpatient facility
99241	▪ 99201 (new patient level 1) or 99211 (established patient level 1)	▪ 99281 (ER visit level 1)
99242	▪ 99202 (new patient level 2) or 99212 (established patient level 2)	▪ 99282 (ER visit level 2)
99243	▪ 99203 (new patient level 3) or 99213 (established patient level 3)	▪ 99283 (ER visit level 3)
99244	▪ 99204 (new patient level 4) or 99214 (established patient level 4)	▪ 99284 (ER visit level 4)
99245	▪ 99205 (new patient level 5) or 99215 (established patient level 5)	▪ 99285 (ER visit level 5)

Crosswalks for Inpatient Consultations

Consultative Services Code	E/M Codes for Inpatient Consultations	Codes for Emergency Department Consultations requiring admission of patient into inpatient facility
99251	▪ 99221 (Inpatient Initial Visit, level 1)	▪ 99221 (Inpatient Initial Visit, level 1)
99252	▪ 99221 (Inpatient Initial Visit, level 1) or 99222 (Inpatient Initial Visit, level 2)	▪ 99221 (Inpatient Initial Visit, level 1) or 99222 (Inpatient Initial Visit, level 2)
99253	▪ 99222 (Inpatient Initial Visit, level 1)	▪ 99222 (Inpatient Initial Visit, level 1)
99254	▪ 99222 (Inpatient Initial Visit, level 2) or 99222 (Inpatient Initial Visit, level 3)	▪ 99222 (Inpatient Initial Visit, level 2) or 99222 (Inpatient Initial Visit, level 3)
99255	▪ 99223 (Inpatient Initial Visit, level 3)	▪ 99223 (Inpatient Initial Visit, level 3)

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
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.
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.

Modifier	Descriptor
NA	Not Applicable

ICD-10 Codes	Descriptor
NA	Not Applicable

Definitions

Office of Inspector General (OIG)

The OIG is a division within the United States Department of Health and Human Services (HHS). The OIG was established in 1976 to fight waste, fraud and abuse in Medicare, Medicaid and other HHS programs. The organization assists the health care industry by conducting health audits, investigations and evaluations to ensure compliance with nationwide fraud and abuse laws. The OIG also serves to educate the public about fraudulent schemes so that consumers can protect themselves and understand the process for reporting suspicious activities.

Additional Information

Not applicable.

Related Documents or Resources

- https://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf

References

1. *Current Procedural Terminology (CPT)®*, 2024
2. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services.

Revision History	
08/11/2017	Original Policy Draft
11/25/2017	Update wording in Utilization section "appropriate level of office visit, initial inpatient visit or emergency department procedure code"
04/24/2019	Conducted review, verified codes and updated policy
04/26/2020	Conducted review, verified codes and updated policy and removed eff date
04/26/2021	Conducted review, verified codes, updated copyright
05/04/2022	Conducted review, verified codes, update copyright dates
08/30/2022	Removed broken link
04/17/2023	Conducted annual review, removed deleted codes 99241 and 99251, verified codes and updated descriptions per current CPT terminology, updated copyright dates
06/13/2024	Conducted annual review, verified codes and updated policy

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.