# Payment Policy: Inpatient Consultation

Reference Number: CC.PP.038
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 12/05/2024

Coding Implications
Revision Log

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

**Policy Overview**
In accordance with the American Medical Association's Current Procedural Terminology (CPT®) guidelines, an Evaluation and Management (E/M) service that is rendered at the request of another physician or other appropriate source, is called a consultation. The purpose of the consultation is to either recommend care for a particular condition or problem, or to decide whether to take on responsibility for the patient's ongoing care or just a specific condition or problem.

The OIG reported that the consultation for services differs from other E/M services in that a consultation involves a specific request for help with a particular diagnosis or course of treatment during a limited amount of time.

The proper E/M procedure code for the place of service should be noted if, following the consultation, the consultant takes over management of all or a portion of the patient's condition(s).

The purpose of this policy is to outline how the health plan evaluates CPT Inpatient or Observation Consultations codes 99252-99255 and Inpatient Follow-up Consultation Telehealth HCPCS codes G0406-G0408 for reimbursement, particularly identifying those that should have been billed at the appropriate level of subsequent hospital care.

CMS does not recognize consultation codes 99242-99245 or 99252-99255 for Medicare payment; therefore, providers should not bill these codes for Medicare members. Instead, for Medicare members providers should report the appropriate E/M code that is documented and payable under the fee schedule (including for visits that could be described by CPT consult codes), that identifies where the visit occurred, and the complexity of the visit performed.

**Application**
Professional and Inpatient Institutional Claims with the same member and same provider

**Reimbursement**
Claim lines that contain an inpatient consultation procedure code billed within five days of another inpatient consult procedure are denied.

Services initiated by a parent and/or family and not requested by a physician or other appropriate source should not be reported using the CPT Inpatient or Observation Consultations codes 99252-99255 or HCPCS Follow-up Inpatient Consultation Telehealth codes G0406-G0408, but

may be reported using appropriate office visit, hospital care, home service or domiciliary/rest home care codes.

CPT guidelines state that only one inpatient consult code should be reported by a consultant per admission. E/M services that occur after the initial consultation during a single admission should be reported using non-consultation E/M codes. The appropriate follow up codes for the hospital setting are CPT codes 99231-99233, and the appropriate follow up codes for the nursing facility setting are CPT codes 99307-99310.

**Documentation Requirements**
The following criteria apply:

- A written or verbal request for consult must be made by an appropriate source as outlined in 42 CFR § 411.351 and OIG Report.
- The request must be documented in the patient's medical record.
- The consultant's opinion must be documented in the patient's medical records.
- The consultant's opinion must be communicated by written report to the requesting physician or other appropriate source.

| CPT/HCPCs Code Descriptions | |
|---|---|
| 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. |
| G0406 | Follow-up Inpatient Consultation, limited, physicians typically spend 15 minutes communication with the patient via telehealth |
| G0407 | Follow-up Inpatient Consultation, limited, physicians typically spend 15 minutes communication with the patient via telehealth |
| G0408 | Follow-up Inpatient Consultation, limited, physicians typically spend 15 minutes communication with the patient via telehealth |

**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 2025, 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.

**References**

1. Current Procedural Terminology (CPT®) 2025
2. HCPCs Level II, 2025
3. CPT Evaluation and Management (E/M) Code and Guideline Changes https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
4. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf
5. https://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf
6. https://www.cms.gov/files/document/r12449cp.pdf
7. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf
8. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411/subpart-J/section-411.351
9. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1725B3.pdf

| Revision History | |
|---|---|
| 11/11/2016 | Initial Policy Draft Created |
| 02/28/2017 | Included correct billing principles updated payment information for Medicare |
| 03/10/2018 | Reviewed and revised policy, validated codes. |
| 03/30/2019 | Conducted review, verified codes, and updated policy. |
| 11/01/2019 | Annual Review completed |
| 11/01/2020 | Annual Review completed |
| 11/30/2021 | Annual review completed; no major updates required |
| 12/01/2022 | Annual review completed; removed code tables since this info can be found in CPT resources |
| 12/01/2023 | Annual Review completed |
| 3/04/2024 | Annual Review completed; Removed “consult codes” and replaced with “Inpatient or Observation Consultations” and “Inpatient Follow-up Consultation Telehealth” in policy; Included the word “documented” in 4th paragraph; Added Code Descriptions for clarification Included links from CMS, OIG, and updated links. |
| 12/05/2024 | Annual review completed; updated links, updated references to reflect the latest guidance, updated font for consistency |
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**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.