CENTENE Corporation

Payment Policy: Inpatient Consultation

Reference Number: CC.PP.038
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 11/30/2021

Coding Implications
Revision Log

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

Policy Overview

The American Medical Association (AMA) Current Procedural Terminology (CPT®) book describes a consultation as a type of evaluation and management (E&M) 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.

If, subsequent to the completion of the consultation, the consultant assumes responsibility for the management of a portion of all of the patient's condition(s), the appropriate Evaluation and Management (E&M) procedure code for the location of service should be reported. 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.

The purpose of this policy is to outline how the health plan evaluates CPT consultation codes 99251-99255 and HCPCS codes G0406-G0408 for reimbursement, particularly identifying those that should have been billed at the appropriate level of subsequent hospital care.

CMS no longer recognizes codes 99241-99245 and 99251-99255 for Medicare payment; therefore, providers should never bill these codes for Medicare members. Instead, (for Medicare members) providers should report the appropriate Evaluation and Management code payable under the fee schedule (including for visits that could be described by CPT consultation codes), that identifies where the visit occurred and the complexity of the visit performed.

Application

1. Professional
2. Inpatient Institutional Claims
3. Same Member
4. Same Provider

Reimbursement

Claim lines that contain an inpatient consultation procedure code billed within five days of another inpatient consultation procedure will be 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 consultation codes 99251-99255 or HCPCS consultation 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 consultation 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
- 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

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 2021, 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
99251	Inpatient consultation for a new or established patient (20 Min)
99252	Inpatient consultation for a new or established patient (40 Min)
99253	Inpatient consultation for a new or established patient (55 Min)
99254	Inpatient consultation for a new or established patient (80 Min)
99255	Inpatient consultation for a new or established patient (110 Min)
G0406	Follow-up inpatient consultation (15 Min)
G0407	Follow-up inpatient consultation (25 Min)
G0408	Follow-up inpatient consultation (35 Min)
99231	Subsequent hospital care, per day (15 Min)
99232	Subsequent hospital care, per day (25 Min)
99233	Subsequent hospital care, per day (35 Min)
99307	Subsequent nursing facility care, per day (10 Min)
99308	Subsequent nursing facility care, per day (15 Min)
99309	Subsequent nursing facility care, per day (25 Min)
99310	Subsequent nursing facility care, per day (35 Min)

Modifier	Descriptor
NA	Not Applicable

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ICD-10 Codes	Descriptor
NA	Not Applicable

Related Documents or Resources
Not Applicable

References

1. *Current Procedural Terminology (CPT®)*, 2021

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

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.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. 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.

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