

Payment Policy: Outpatient Consultations

Reference Number: CC.PP.039

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's (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.

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

The purpose of this policy is to outline how the health plan evaluates CPT consultation codes 99241-99245 and HCPCS codes G0425-G0427 for reimbursement, particularly identifying those that should have been billed at the appropriate level of office visit, established patient or 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. Outpatient Institutional Claims
3. Same member
4. Same Provider

Reimbursement

Claim lines that contain an outpatient consultation, when another outpatient consultation was billed by the same provider within six months, 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 99241-99245 or HCPCS consultation codes G0425-G0427, but may be reported using appropriate office visit, hospital care, home service or domiciliary/rest home care codes.

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CPT guidelines state that only one outpatient consultation should be reported by the same consultant within a six month period. Follow up visits in the consultant’s office or other outpatient facility that are initiated by the consultant or patient are reported using the appropriate codes for established patients, office visits (99211-99215), domiciliary, rest home (99334-99337), or home (99347-99350). If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office consultation codes may be used again.

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
99241	Office consultation for a new or established patient (15 Min)
99242	Office consultation for a new or established patient (30 Min)
99243	Office consultation for a new or established patient (40 Min)
99244	Office consultation for a new or established patient (60 Min)
99245	Office consultation for a new or established patient (80 Min)
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth

Modifier	Descriptor
NA	Not Applicable

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ICD-10 Codes	Descriptor
NA	Not Applicable

Definitions

Not Applicable

Related Policies

Not Applicable

Related Documents or Resources

Not Applicable

References

1. *Current Procedural Terminology (CPT®)*, 2021
2. *HCPCS Level II*, 2021

Revision History	
11/11/2016	Initial Policy Draft Created
03/14/2017	Included correct billing principles updated payment information for Medicare
03/10/2018	Reviewed and Revised policy. Validated Codes
03/10/2019	Conducted review, verified codes, and updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/01/2021	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

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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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