Medical Policy

Consultation Services

Policy Number: PG0291
Last Reviewed Date: 04/01/2025
Last Revised:04/01/2025

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

X Professional
_ Facility

DESCRIPTION:

A consultation is a unique type of evaluation and management service provided at the request of another physician, qualified nurse practitioner, or other appropriate source to recommend or give advice, opinion, suggestion, direction, or counsel, etc., in evaluating or treating a patient because that provider has expertise in a specific medical area beyond the requesting professional's knowledge. Patients seen in consultation may be either new patients or established patients.

POLICY:

Paramount Commercial Insurance Plans
Effective April 1, 2023:

- **Paramount will expand the Non-covered Consultation Services Payment Policy to include its Commercial products. In doing so, Paramount now more fully aligns itself with the Centers for Medicare & Medicaid Services' (CMS's) standards by no longer recognizing Current Procedural Terminology (CPT) consultation codes (99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255) as being eligible for reimbursement for its commercial and Medicare Advantage membership.**

Elite (Medicare Advantage) Plans
Effective January 1, 2010:

- **Consultation services (99241-99245 and 99251-99255) are non-covered for Elite/ProMedica Medicare Plan**

COVERAGE CRITERIA:

Elite (Medicare Advantage) Plans

Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) no longer reimburses physicians for CPT consultation codes 99241-99245 or 99251-99255 and these codes will therefore not be recognized as reimbursed services for Elite/ProMedica Medicare Plan members. This includes when reported with telehealth modifiers for any practice or care provided. Instead, (for Elite/ProMedica Medicare Plan 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. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services.

While these services may be valid (AMA/CPT) and reportable (HCPCS) codes, it does not make them reimbursable. The AMA/CPT does not establish reimbursement guidelines; only the codes by which reimbursement is performed.

Paramount continues to consider initial inpatient, follow-up inpatient, critical care and emergency department consultations performed via telehealth for reimbursement. These services are represented by HCPCS codes G0406-G0408, G0425-G0427, and G0508-G0509.

Paramount Commercial Insurance Plans

Effective 4/1/2023, Paramount will expand the Non-covered Consultation Services Payment Policy to include its Commercial products. In doing so, Paramount now more fully aligns itself with the Centers for Medicare & Medicaid Services' (CMS's) standards by no longer recognizing Current Procedural Terminology (CPT) consultation codes (99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255) as being eligible for reimbursement for its Commercial and Elite (Medicare Advantage) membership.

Physicians and NPPs who furnish services that, prior to April 1, 2023, would have been reported as CPT consultation codes, should report the appropriate E/M visit code to bill for these services beginning April 1, 2023. Consultation services should be reported with an appropriate Evaluation and Management (E&M) code that represents the location where the visit occurred and the level of complexity of the visit performed. Such locations include, but are not limited to, the office or other outpatient setting, the inpatient hospital setting, or nursing facility setting.

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
99242	Office of 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 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.
HCPCS CODES	
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes communicating with the patient via telehealth
G0508	Telehealth consultation, critical care, initial, physician typically spend 60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physician typically spend 50 minutes communicating with the patient and providers via telehealth

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 12/01/2009

Date	Explanation & Changes
06/14/2016	• Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
12/18/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/01/2023	• Policy reviewed and updated to reflect most current clinical evidence • Paramount added HCPCS procedure codes G0406, G0407, G0408, G0425, G0426, G0427, G0508, G0509 • Paramount updated CPT procedure code descriptions for 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255 • Paramount removed deleted procedure codes 99241 and 99251 • **Paramount will expand the Non-covered Consultation Services Payment Policy to include its Commercial products. In doing so, Paramount now more fully aligns itself with the Centers for Medicare & Medicaid Services' (CMS's) standards by no longer recognizing Current Procedural Terminology (CPT) consultation codes (99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255) as being eligible for reimbursement for its Commercial product lines**
02/17/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
03/07/2024	• Medical policy placed on the new Paramount Medical Policy Format
04/01/2024	• Medical policy reviewed and updated to reflect the most current clinical evidence
04/01/2025	• Medical policy reviewed and updated to reflect the most current clinical evidence

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to
https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23- Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits
U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review