PAYMENT POLICY ID NUMBER: 17-055

Original Effective Date: 05/11/2017

Revised: 05/08/2025

Consultation Services

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS 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, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem. Effective January 1, 2023, the appropriate level of consultation services should be selected based on a medically appropriate history and/or examination and the level of the Medical Decision Making (MDM) as defined for each service or the total time personally performed by the physician or other qualified health care professional for the evaluation and management (E/M) service performed on the date of the encounter.

This policy applies to billing for services on a CMS-1500 or equivalent claim form. Same provider for the purposes of this policy includes all physicians and/or other health care professionals reporting under the same Federal Tax Identification number.

REIMBURSEMENT INFORMATION:

Special note for Florida Blue Medicare Advantage products: Consistent with the Centers for Medicare & Medicaid Services (CMS) guidelines, Florida Blue does not recognize consultation procedure codes 99242-99245 and 99252-99255 for our Medicare Advantage products. Providers should code a patient E/M visit with procedures that represent where the visit occurs and identifies a visit's complexity using procedure codes 99202-99215, 99221-99223, and 99304-99306, as appropriate.

The following would apply to all Florida Blue commercial products:

As stated in CPT®, the consultant's opinion and any services that were ordered or performed must be communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source.

As with any reported service, documentation must support the codes reported. For consultation services, this would include a request for the consultation and the written report to the requesting provider. In order for Florida Blue to consider a consultation service for reimbursement, the requesting physician or other qualified source must be identified on the claim. If the requesting entity is not identified on the claim, the consultation service will be returned or denied as it does not meet basic CPT® requirements for reporting such a procedure.

Consultation procedures should not be reported by the physician or other qualified heath care professional who has agreed to accept transfer of care.

Services initiated by a patient and/or family and not requested by a physician, other qualified health care professional, or other appropriate source should not be reported using CPT® consultation codes 99242-99245 or 99252-99255 or HCPCS consultation codes G0406-G0408, G0425-G0427, G0508, or G0509 but may be reported using appropriate office visit, hospital care, home and residence service procedure codes.

A claim for E/M services that does not meet the criteria as a consultation may be submitted (or resubmitted) with an appropriate non-consultation E/M procedure code and it will be considered for reimbursement.

In addition, CPT® guidelines state that only one inpatient consultation (99252-99255) should be reported by a consultant per admission. Florida Blue will only consider one inpatient consultation (99252-99255) per admission, by the same physician or other health care professional. E/M services after the initial consultation during a single admission should be reported using non-consultation E/M procedure codes.

Follow up visits in the consulting physician's office or other outpatient facilities that are initiated by the consultant or patient are reported using the appropriate E/M visit code. If an additional request for an opinion or advice regarding the same or new problem is received from another physician or appropriate source, the office consultation code may be used again. This additional request must be documented in the patient record and may be requested by Florida Blue to verify the appropriate usage of the consultation procedure.

BILLING AND CODING:

The following codes represent consultation services:

CPT® Codes:

CPT® Code	Description
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 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.

CPT® Code	Description
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:

HCPCS Code	Description
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, physicians typically spend 60 minutes communicating with the patient and providers via telehealth.
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth.

REFERENCES:

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services, Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners, 30.6.10 - Consultation Services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
3. American Medical Association, Current Procedural Terminology (CPT®) E/M Companion 2023

GUIDELINE UPDATE INFORMATION:

05/11/2017	Payment Policy Approved by Payment Policy Committee
05/11/2017	Effective date of new payment policy
05/18/2018	Annual Review; added instructions regarding follow up visits.
05/16/2019	Annual Review
05/14/2020	Annual Review
05/13/2021	Annual Review
05/12/2022	Annual Review; References updated
01/01/2023	Revision; Policy revised to align with new reporting guidelines for E/M services and consultation CPT® codes.
05/11/2023	Annual Review – References reviewed and updated
05/09/2024	Annual Review – References reviewed and updated.
05/08/2025	Annual Review – Clarifying language added to indicate this policy applies to billing for services on a CMS-1500 or equivalent claim form. Minor wording changes in the Description section. References reviewed and updated.