Payment Policy: Inpatient Consultation

Reference Number: LA.PP.038
Effective Date: 08/2020
Last Review Date: 06/2026

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.

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 Louisiana Healthcare Connections evaluates CPT Inpatient or Observation Consultation 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 no longer recognizes codes 99242-99245 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 that is documented and 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
Inpatient consultation claims will be processed according to Louisiana Medicaid policy and the applicable provider manuals.

When services are initiated by a parent and/or family and are not documented as having been requested by physician or other appropriate source, the service may not meet the criteria for reporting CPT inpatient or observation consultation codes 99252-99255 or HCPCS inpatient

follow-up consultation telehealth codes G0406-G0408. In such cases, providers should consider reporting the most appropriate Evaluation and Management codes consistent with the service rendered, documentation, and Louisiana Medicaid guidelines.

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 2026, 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
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.

Modifier	Descriptor
NA	Not Applicable

ICD-10 Codes	Descriptor
NA	Not Applicable

Related Documents or Resources
Not Applicable

References
1. *Current Procedural Terminology (CPT®)*, 2026
2. *HCPCS Level II, 2026*
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.pdf7. 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	Revision Date	Approval Date	Effective Date
Converted corporate to local policy.	08/15/20		
Annual Review; Updated dates in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section	08/30/22		
Annual Review	07/26/23	9/12/23	10/25/23

Revision History	Revision Date	Approval Date	Effective Date
Annual review; Removed "consult codes" and replaced with "Inpatient or Observation Consultations" and "Inpatient Follow-up Consultation Telehealth"; Included the word " documented" in 4th paragraph; Removed the subsequent hospital codes from the list. Added code Descriptions for clarification; updated links and references to reflect the latest guidance. Added clarifying information under reimbursement portion.	06/25	6/8/26	7/8/26
Annual review; dates updated	06/26	6/30/26	

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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 payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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