

Consultation Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and Other Qualified Health Care Professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and Other Qualified Health Care Professionals.

Policy

Overview

This policy discusses how UnitedHealthcare evaluates CPT® consultation codes 99242-99245 and 99252-99255 and Healthcare Common procedure Coding System (HCPCS) codes G0406-G0408 and G0425-G0427 for reimbursement.

Reimbursement Guidelines

Consultation Services

The American Medical Association (AMA) 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.

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

UnitedHealthcare Community Plan Medicaid:

UnitedHealthcare Community Plan will consider a claim for a consultation service for reimbursement for Medicaid members if the requesting or referring provider or other appropriate source is identified on the claim. If the requesting or referring entity is not identified on the claim, the consultation service will be denied because it does not meet basic AMA requirements for reporting such a code.

Note: AMA guidelines state that only one inpatient consultation (99252-99255) should be reported by a consultant per admission. E/M services after the initial consultation during a single admission should be reported using non-consultation E/M codes.

State Exceptions

Arizona	AZ Medicaid is exempt from the referring provider requirement.
Missouri	Per state regulations, Missouri Medicaid is excluded from this policy.
Indiana	Per state regulations, Indiana Medicaid is excluded from this policy.

Definitions

Consultation Service	<p>A type of evaluation and management 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 following criteria also apply:</p> <p>A written or verbal request for consult must be made by an appropriate source.</p> <ul style="list-style-type: none"> • The request must be documented in the patient’s medical record • The consultant’s opinion must be documented in the patient’s medical record • The consultant’s opinion must be communicated by written report to the requesting physician or other appropriate source
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Questions and Answers

1	<p>Q: Who are considered “appropriate sources” for a consultation service reported with a consultation code?</p> <p>A: Per the AMA, examples of appropriate sources for a consultation request may include a physician, physician assistant, nurse practitioner, psychologist, social worker, etc.</p>
2	<p>Q: What are examples of sources when it is not appropriate for a physician or Other Qualified Health Care Professional to report a consultation service code?</p> <p>A: The patient and the patient’s family are not considered appropriate sources for reporting a consultation code.</p>
3	<p>Q: If a consultation code is not appropriate to report, or a claim for a consultation code has been denied because an appropriate referring entity has not been identified on the claim, how should the E/M services be reported?</p> <p>A: 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 code and it will be considered for reimbursement.</p>
4	<p>Q: Where on the claim form or claim submission should the requesting entity be reported? What type of identification is necessary?</p> <p>A: If the requesting entity has a National Provider Identification (NPI) number, that number should be in field 17B of the CMS-1500 form (also known as the 1500 claim form) or its electronic equivalent. If the requesting entity does not have an NPI number, his or her name should be in field 17 of the claim form. As with all claim submissions, all fields should be completed with valid and accurate information.</p>

Resources

Individual state Medicaid contracts, regulations, manuals & fee schedules
American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

History

7/30/2025	Policy Overview and Version Updated
7/1/2025	Annual Anniversary Date and Version Change History prior to 7/1/2023 archived
10/13/2024	Policy Version Change State exceptions section: Removed Virginia
3/31/2024	Policy Version Change State exceptions section: Removed Kansas
9/1/2016	Policy implemented by UnitedHealthcare Community Plan
1/13/2016	Policy approved by the Payment Policy Oversight Committee