

Clinical Policy: Consultations

Reference Number: CP.VP.15

Last Review Date: 08/2025

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

A consultation visit performed by specialists at the request of a referring physician. This policy describes medical necessity for a consultation.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] (Centene) and Envolve Vision, Inc.[®] (Envolve) that consultations are **medically necessary** for the following indications:
 - A. When the referring provider's expertise, knowledge or scope of practice does not include the skills necessary to resolve the patient's specific condition.
- II. It is the policy of health plans affiliated with Centene and Envolve that transfer of care is not considered a form of referral and does not meet the requirements for billing a consultation.

Background

The intent of a consultation is that a referring professional is asking the consultant for help (e.g., an opinion or direction) in evaluating or treating a patient because that consultant has expertise in a specific medical area beyond the requesting professional's knowledge. A consultant may initiate diagnostic and /or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visits. After the consultation is provided, the consultant prepares a written report of the findings, which is provided to the referring physician.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical 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 [®] Codes	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 a medically appropriate history and/or examination and straightforward

CPT® Codes	Description
	medical decision making. When using total time on the date of the encounter for code selection, 20 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.

Medicare does not cover consultation codes. When these services are provided, the appropriate E/M code should be reported. *See clinical policy CP.VP.41 Medical Eye Examinations.*

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template	09/2020	10/2020
Annual Review	12/2020	12/2020
Annual Review	12/2021	12/2021
Annual Review; Revised CPT code descriptors in accordance with AMA modifications; Removed deleted CPT code 99241.	11/2022	11/2022
Annual Review	11/2023	12/2023
Annual Review	11/2024	12/2024
Annual Review	08/2025	10/2025

References

1. Center for Medicare and Medicaid Services (CMS), Claims Processing Manual, Chapter 12, Section 30.6.10 – Consultations
2. Vicchilli S. Office Visit or Consultation? Here's How to Make the Call. EyeNet Magazine. American Academy of Ophthalmology; September 2020.
3. CPT Evaluation and Management (E/M0 Code and Guideline Changes. American Medical Association. 2022. <https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf>

Important Reminder

This clinical 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 clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical 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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical 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 clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical 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 clinical 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 clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical 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 clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <https://www.cms.gov> for additional information.

©2025 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international

copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene[®] and Centene Corporation[®] are registered trademarks exclusively owned by Centene Corporation.

©2025 Envolve, Inc. All rights reserved. All materials are exclusively owned by Envolve and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Envolve. You may not alter or remove any trademark, copyright or other notice contained herein.