



Correct Coding and Documentation Resource Sheet

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Originated Department	Correct Coding Integrity

E/M Consultation Services Educational Guide

Audience
- Clinical Providers (Physicians, NPs, PAs, Specialty Consultants) - Medical Coders & CDI Specialists - Compliance and Audit Staff

CPT 2026 Consultation Codes & Typical Time				
Consultation - A service provided when a physician or qualified health professional is asked by another provider for an opinion on a patient's specific problem. Key Elements: - Review of patient record / history - Interview and/or physical exam - Formulation of opinion / management plan - Communication with requesting provider CPT Codes (2026): Outpatient: 99242–99245 Inpatient: 99252–99255 Tip: If the patient becomes your ongoing patient, future visits are coded as established patient E/M (99211–99215).				
Setting	CPT Code	Typical Time on Date of Service	MDM Level	Notes
Outpatient	99242	30–39 min	Low	Problem-focused exam, moderate MDM
Outpatient	99243	40–54 min	Moderate	Expanded problem-

				focused exam
Outpatient	99244	55–69 min	Moderate	Detailed exam, high MDM
Outpatient	99245	70–84 min	High	Comprehensive exam, high MDM
Inpatient	99252	35–44 min	Low	Problem-focused, low complexity
Inpatient	99253	45–59 min	Moderate	Expanded problem-focused
Inpatient	99254	60–74 min	Moderate	Detailed exam
Inpatient	99255	75–89 min	High	Comprehensive exam, high complexity
MDM Highlights for Consultation Services				
Component	Minimal	Low	Moderate	High
Problems	1 self-limited	2 minor	1 stable chronic / multiple minor	1+ severe chronic / acute
Data	Minimal	Limited	Moderate	Extensive (labs, imaging, outside records)
Risk	Minimal	Low	Moderate	High (life-threatening / severe disability)
Educational Tip: Always document the problem, data reviewed, and risk to justify code selection.				

Documentation Essentials:

1. For each consultation, documentation should include:
 - 1.1 Requesting Provider:** Name and specialty
 - 1.2 Reason for Consultation:** Clear clinical question
 - 1.3 History of Present Illness (HPI):** Detailed and relevant to the problem
 - 1.4 Physical Exam Findings:** Problem-focused or comprehensive
 - 1.5 Medical Decision Making (MDM):**
 - a) Number/complexity of problems
 - b) Data reviewed, ordered, or analyzed
 - c) Risk of complications or morbidity
 - 1.6 Assessment & Plan:** Consultant's opinion, differential diagnosis, recommendations

- 2. Communication:** Document discussion / recommendations with requesting provider
- 3. Time-Based Coding Option:**
 - 3.1** If counseling / care coordination dominates ($\geq 50\%$), total time may determine code.
 - 3.2** Document: time spent, activities, and participants.
- 4. Example**
 - 4.1** *"Total 30 min: 20 min counseling patient/family, 10 min reviewing outside labs and imaging. Discussed plan with requesting provider."*

CDI & Audit Considerations

1. Always document the consultation request and reason
2. Include all data reviewed (labs, imaging, outside records)
3. Specify complexity and risk—avoid generic phrases
4. Document communication to requesting provider
5. Review for completeness and clarity

Common Audit Triggers:

1. Missing requesting provider
2. Incomplete exam documentation
3. Ambiguous MDM justification
4. Missing communication documentation

References

CPT 2026 Professional Edition, AMA
 AMA CPT Assistant, consultation guidance
 CMS Evaluation & Management Services Guide
 Official ICD-10-CM / CPT coding rule

Review/Revision/Approval History

Date	Description
01/01/2026	Correct Coding Integrity
03/23/2026	Revised by Mountain Health CO-OP Policy Committee

Disclaimer

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