Interprofessional Services

When providing services to a patient calls for the physician to consult with a specialist there are codes that may be used, with patient consent (as there may be a cost to the patient), to capture the services rendered. When considering billing for these services there are a few things of which to be aware.

- Both the requesting and consulting physicians will submit codes
- The consulting physician will not have an encounter with the patient, rather will communicate with the requesting physician only
- The requesting physician will communicate the results of the consultation to the patient
- If a visit to the consulting physician for the same problem has occurred in the 14 days prior or will occur in the 7-14 days after the consultation, the services are not billable

The following codes are used to represent services provided to patients that require a physician to consult another physician (i.e., a specialist) and the consultation is performed via telephone, internet, or other electronic means (i.e., in-basket messaging within the EMR). UHA has added codes 99446-99449, 99451, 99452 to Epic as AMB LEVEL OF SERVICE codes.

CPT Code	Description
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	11-20 minutes of medical consultative discussion and review
99448	21-30 minutes of medical consultative discussion and review
99449	31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

INCLUDES/EXCLUDES NOTES:

- **99446-99451**
  - **Includes:**
    - Verbal and written reports from the consultant to the requesting provider
  - **Excludes:**
    - Prolonged services without direct patient contact (99358-99359)
    - Use of code more than one time in 7 days
- **99452**
  - **Includes:**
    - Time preparing for referral of 16 to 30 minutes
  - **Excludes:**
    - Requesting physician's time 30 minutes over the typical E&M service,
      - patient not on site (99358-99359)
      - patient on site (99354-99357)
    - Use of code more than one time every 14 days

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Custom Codes

The following custom codes are to be used when:

- CC3234 - ECONSULT - REFERRED TO SPECIALIST [0.7 wRVU (not billable to insurance)]
  - services are rendered, yet not billable to insurance (i.e., the econsult time requirements are met and an appointment is made for the consulting physician to see the patient within the next 14 days), or
- CC2224 - NO BILLABLE SERVICE PROVIDED
  - services are provided but time requirements are not met (i.e., less than 5 minutes by the consultative MD or less than 16 minutes by the requesting MD)

From the AAP Division of Health Care Finance

January 04, 2019

Current Procedural Terminology (CPT) codes 99446-99449 were created in 2014 to capture the time spent by a consultant who is not in direct contact with the patient at the time of service.

An interprofessional telephone/internet consultation (ITC) is defined as an assessment and management service in which a patient's treating (e.g., attending or primary) physician/other qualified health care professional (QHP) requests the opinion and/or treatment advice of a consultant with specific specialty expertise to assist the treating physician/QHP in the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consultant.

Consultant codes 99446-99449 and 99451:

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- *Can be reported*
  - for new or established patients
  - for a new or exacerbated problem

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- *Cannot be reported*
  - more than once per seven days for the same patient

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- *Are reported*
  - only by a consultant when requested by another physician/QHP
  - based on cumulative time spent, even if that time occurs on subsequent days

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- *Are not reported*
  - if a transfer of care or request for a face-to-face consult occurs as a result of the consultation within the next 14 days
  - if the patient was seen by the consultant within the past 14 days

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- *Requires*
  - that the request and the reason for the request for the consult be documented in the record
  - verbal consent for the interprofessional consultation from the patient/family documented in the patient's medical record

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Requesting/treating physician/QHP code 99452:

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- *Can be reported*
  - with prolonged services, non-direct

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- *Cannot be reported*
  - more than once per 14 days per patient

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- *Is reported*
  - by the physician/QHP who is treating the patient and requesting the non-face-to-face consult for medical advice or opinion — and not for a transfer of care or a face-to-face consult
  - only when the patient is not on-site and with the physician/QHP at the time of the consultation

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- *Includes*
  - time preparing for the referral and/or communicating with the consultant

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- *Requires*
  - a minimum of 16 minutes

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Interprofessional Services

From the Nixon Law Group – On Interprofessional Consultations

Beginning January 1, 2019, physicians and other Qualified Healthcare Providers ("QHCPs") eligible to independently bill for E/M services can obtain standalone reimbursement for Interprofessional Internet Consultations according to the following parameters:

- **Billing Practitioner** - Billing for interprofessional services is limited to those practitioners that can independently bill Medicare for E/M services. Though the descriptors for codes 99446-99449 and 99451 only include "assessment and management service provided by a **consultative physician**," the text in the Rule includes consultative QHCPs, so long as the consulting QHCP is eligible to independently bill Medicare for E/M services. CPT Code 99452 applies to the treating/referring physician or QHCP, and the rest of the codes apply to the consultative physician or QHCP.
- **Consent** - Verbal patient consent must be documented in the patient's medical record for each consultation. The patient's consent must include assurance that the patient is aware of applicable cost-sharing.
- **Cost Sharing** - Providers must collect the requisite copayment from the patient for each service billed, as with all Medicare Part B services.
- **Benefit of the Patient** - The consultation must be undertaken for the benefit of the patient. Because the patient is going to be responsible for cost-sharing, CMS is concerned about distinguishing these Interprofessional Internet Consultations from those undertaken for the edification of the practitioner, such as information shared as a professional courtesy or as continuing education.

Interprofessional internet consultation (CPT®1 codes 99446-49 and 99451-52)
CMS also finalized its proposal to pay separately for four existing and two new Current Procedural Terminology (CPT®) codes describing consultations between physicians or other qualified health professionals when they are for the benefit of a specific patient. These consultations occur when a treating physician seeks the opinion and/or treatment advice of a consulting physician or other health professional with specific expertise, and CMS noted that the current lack of reimbursement for these interactions often leads to the scheduling of an office visit for the patient even though the patient's presence is not necessary and a telephone or internet consultation between health care professionals would be sufficient. CMS views its recognition of these services as part of the movement away from a strictly fee-for-service-based system and toward a more care management-based approach to providing quality care to beneficiaries with multiple complex conditions. CMS is requiring documentation of beneficiary consent to receive these services because they will be subject to coinsurance, and it will monitor use of the consultations and consider refinements in documentation and billing policies if warranted.

Click here for video instruction for workflow and how to capture the codes for the service.

Resources:

- https://www.aappublications.org/news/2019/01/04/coding010419
- https://www.encoderpro.com
- https://www.nixonlawgroup.com/nlg-blog/reimbursement-interprofessional-internet-consultations-new-cpt-codes
- https://mtelehealth.com/medicare-expands-payment-for-telehealth-and-remote-patient-monitoring-services/

Interprofessional Services

EXAMPLE 1:

Patient seen by physician consents to have physician consult with specialist regarding problem. Physician spends 7 minutes preparing for meeting with specialist regarding problem. Specialist agrees to consult and meets with physician for 15 minutes to discuss the nature of the problem and possible treatment options. Following the discussion, the consulting physician writes a report documenting the discussion, and the possible treatment options and sends the written report to the requesting physician and documents the total cumulative time spent for reviewing information sent, discussing the problem with, and writing and returning the report to the requesting physician.

EXAMPLE 1	**Requesting Physician**	**Consulting Physician**
Time preparing/reviewing requesting physician's information regarding the problem	7 minutes preparing	7 minutes reviewing
Time spent in discussion between the requesting/consulting physicians	15 minutes discussing	15 minutes discussing
Time spent writing report to send to requesting physician	N/A	10 minutes writing report
Total time spent for consultation	22 minutes	32 minutes
Codes Reported	99452	99449

EXAMPLE 2

Patient consents to have physician consult with specialist regarding problem. Requesting physician spends 16 minutes to prepare and send information regarding problem to specialist. Specialist reviews information sent by requesting physician recognizes the problem quickly and sends a report with recommendation for treatment, spending a total of 5 minutes.

EXAMPLE 2	**Requesting Physician**	**Consulting Physician**
Time preparing/reviewing requesting physician's information regarding the problem	16 minutes preparing	3 minutes reviewing
Time spent in discussion between the requesting/consulting physicians	N/A	N/A
Time spent writing report to send to requesting physician	N/A	2 minutes writing report
Total time spent for consultation	16 minutes	5 minutes
Codes Reported	99452	99451

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EXAMPLE 3

Patient consents to physician consult with specialist. Requesting physician spends 18 minutes preparing information to send to specialist. Specialist reviews the information and sends a message back to the requesting physician to indicate that it would be best to see this patient in person.

EXAMPLE 3	**Requesting Physician**	**Consulting Physician**
Time preparing/reviewing requesting physician's information regarding the problem	18 minutes preparing	10 minutes reviewing
Time spent in discussion between the requesting/consulting physicians	5 minutes	5 minutes
Time spent writing report to send to requesting physician	N/A	7 minutes writing report
Total time spent for consultation	23 minutes	22 minutes
Codes Reported	Use CC3234 to receive wRVU credit even though services are not billable to insurance	Use CC2224 as specialist will see patient in person