

## Interim Coding Guidance: Interprofessional Consultations during the COVID-19 pandemic

The Society for Maternal-Fetal Medicine (SMFM) Coding Committee; Steve Rad, MD; Trisha Malisch, CCS-P, CPC; Vanita Jain, MD

The SMFM Coding Committee has recently published coding guidance for COVID-19 and pregnancy (<https://www.smfm.org/covid19>). Due to recent concerns about decreasing exposure and social distancing mandates during the pandemic, MFM subspecialists are more frequently participating in telehealth services with both patients as well as with other healthcare providers.

MFM subspecialists frequently are asked by other physicians to provide assistance, opinion and consultation to assist in the diagnosis, management, and treatment of patients without a face-to-face visit. The purpose of this document is to provide MFM consulting subspecialists coding guidance when a physician requests an opinion and/or treatment advice of a consulting physician. The codes are all time-based codes and provided by phone, internet or electronic health record. Due to the rapid and ongoing changes during the pandemic, coding guidance may be subject to change.

### **Interprofessional Codes (99446-99451)**

Interprofessional codes should be utilized by MFMs who communicate with referring OBGYN (or other treating physicians) regarding a diagnosis or management of a patient. These codes are defined as an E/M service in which a patient's treating provider (OBGYN attending) requests the opinion and/or treatment advice of a consultant (MFM attending) with specific specialty expertise to assist the OBGYN in the diagnosis or management of a patient's problem. These services are utilized to help bill/code appropriately for team-based approaches to care, and do NOT include physician time with the patient. **There is no face-to-face encounter on the part of the MFM (consultant).** These codes were updated in 2019 to include assessment of the EMR (electronic medical record) as part of the consultation service. Since the type or severity of the problem is not defined, any condition may qualify for consultative services. However, the codes typically are reported when a new problem arises or a chronic issue is not well-managed or exacerbates. Only the consultant (ie, MFM) can report these codes. **In addition, these codes require both a verbal and written follow-up report.**



The code descriptions are as follows:

- **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 healthcare professional; 5-10 minutes of medical consultative discussion and review
- **99447:** ...11-20 minutes
- **99448:** ...21-30 minutes
- **99449:** ...31 minutes or more
- **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 healthcare professional, 5 minutes or more of medical consultative time. (\*Does not include any verbal interaction between practitioners. It is just a written report.).

**These codes include the following caveats:**

- Can be used for new or established patients
- Can be reported for a new/acute or exacerbated/chronic problem
- Only reported by the consultant (MFM) when requested by another provider
- Can only be reported once in 7 days for the same patient
- Are reported based on cumulative time for those 7 days (even if you consult every day)
- Can NOT be used if a transfer of care or face-to-face consult occurs within next 14 days
- Can NOT be used if you (MFM) saw the patient for face-to-face time in the last 14 days
- Majority of time must be medical consultative verbal or internet discussion (greater than 50%), and appropriately documented. If greater than 50% is in data review and/or analysis, do not bill these codes.
- 99451 may be billed if more than 50% of the 5-minute time is data review and/or analysis
- Written or verbal request should be documented in the patient's medical record, including the reason for the consult

Also, potentially of relevance to MFM, is if a different subspecialty consult/referral is required (eg, neurology, pulmonology, cardiology), and the MFM is the primary/requesting physician, code 99452 can be used.

- **99452:** interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified healthcare professional, 30 minutes

Code 99452 describes the services that the treating physician (if MFM is primary/requesting physician) would spend in preparation for communication with a consulting physician. The treating physician must prepare for the interaction, so he or she uses the consultant's time wisely.

This code includes the following caveats:

- Reported by physician requesting the non face-to-face consult/opinion
- Reported only when patient is NOT on site with the physician at the time of the request
- Can NOT be reported more than once in 14 days and per patient
- Includes time preparing for the referral/discussion with the consultant
- Requires minimum of 16 minutes of time
- Can be reported with prolonged services (99358, 99359)

***It is important for physicians to get the patient's permission for these types of interprofessional consults so that the patient is aware and because they will require a co-pay/cost sharing.***

### **Example**

On Friday afternoon, you Dr. MFM, are contacted by one of your referring OBGYN groups regarding a patient they saw this week, complaining of itching on her palms/soles. The bile acids and LFTS are noted in your hospital system's EMR. Dr. OBGYN wants your opinion about antenatal testing and timing of delivery. The patient is otherwise a 25-year-old G1, who is otherwise healthy at 32 weeks gestation. You have seen her earlier this pregnancy for her anatomy ultrasound. Her pregnancy is managed by Dr. OBGYN. You spend 5 minutes reviewing these lab results, and looking through the patient's last progress note to ensure vitals were normal and no other issues are of concern. You contact Dr. OBGYN by phone and spent about 11 minutes discussing the plan of care. You spend an additional 4 minutes typing up a note that you will fax to their office with your recommendations.

How is this reported?

99447

Total time spent is 20 minutes (5 minutes reviewing chart/prep, 11 minutes discussing the case and plan of care, 4 minutes typing up your note), more than 50% was consultative discussion, included provider verbal interaction.

Please submit any questions you may have to the SMFM Coding Committee Ask a Coding Question website (<https://www.smfm.org/coding/questions/new>). Additional information and resources are also available on our coding website. Thank you very much.

