Society for Maternal•Fetal Medicine

Coding Committee

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Coding Tip: Care Coordination and Interprofessional Consultations

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MFM subspecialists frequently need to speak with other physicians for patient care coordination and/or are asked by other physicians to provide assistance, opinion and consultation to assist in the diagnosis, management, and treatment of patients separate from the patient face-to-face visit. The purpose of this document is to provide MFM consulting subspecialists coding guidance when a physician needs to speak with and coordinate care for their patient and/or when another 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. Furthermore, changes to the 2021 CPT Evaluation and Management (E/M) codes have been made and are applicable in some scenarios.

Coordinating care for patients as part of an outpatient office visit

If a patient is seen for an outpatient MFM office visit and discussion with another specialist, such as pediatric cardiologist or genetic counselor, is required, then "discussion of management or test interpretation with external physician or other QHP" counts as a Data Category 3 Moderate point when billing in the outpatient office using Medical Decision Making (MDM) to identify your E/M Level of Service (LOS). For example, if you saw a patient in the office for fetal anomalies counseling and discussion, then contacted the pediatric cardiologist to discuss your findings and set up a fetal echocardiogram and spoke with your genetic counselor to set up your plans for further testing, then this would be rolled into your E/M LOS for that office visit. Please refer to our 2021 E/M Coding Guidelines Grid for more information in selection of LOS. If you are billing based on Total Time according to the 2021 E/M Coding Guidelines, the time spent in this care coordination would count towards your E/M LOS. Please refer to our 2021 E/M White Paper for further information on how to bill based on Total Time and/or Medical Decision Making. As always, documentation of the care coordination is required.

If there is no related patient encounter in your office and instead you are providing consultation to another physician, then interprofessional codes, described below, would be a more appropriate choice. The original related White Paper on Interprofessional Codes may be found here.

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/consents and because they will be billed and may require a co-pay/cost sharing. Documentation of the patient/family's verbal consent in the medical record is required for each interprofessional consultation service.

<u>Example 1</u>

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.

Example 2

You Dr. MFM sees a patient in clinic with multiple medical problems. You see and evaluate the patient and order tests. While following up your test results, you identify a problem that you would like to discuss with Cardiology. You send a message to the cardiologist requesting a non face-to-face consult to discuss the patient. You prepare and send an e-message via your EHR InBasket to the cardiologist summarizing patient history and clarifying questions. Cardiologist reviews data and either replies by e-message or phone call stating the patient needs x, y, and z, but does not need a face-to-face cardiology consult. You Dr. MFM then summarize the discussion in documentation encounter. Total time spent 35 minutes.

How is this reported?

99452.

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.