Society for Maternal•Fetal Medicine

Coding Committee

November 2013

Coding Tip - New Codes Effective January 1, 2014 Interprofessional Telephone/Internet Consultations (CPT Codes 99446-99449)

99446 Interprofessional telephone/Internet 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 Interprofessional telephone/Internet 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; **11-20 minutes** of medical consultative discussion and review

99448 Interprofessional telephone/Internet 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; **21-30 minutes** of medical consultative discussion and review

99449 Interprofessional telephone/Internet 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; **31 minutes or more** of medical consultative discussion and review

<u>Definition/Guidelines:</u>

The consultant should use the above codes to report interprofessional telephone/internet consultations. An interprofessional telephone/internet consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or treatment of the patient's problem without the need for the patient's face-to-face contact with the consultant.

These services are typically provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be feasible (eg, geographic distance).

The telephone/internet consultation codes should not be reported by the physician who has agreed to accept transfer of care ***before an initial evaluation,*** but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate.

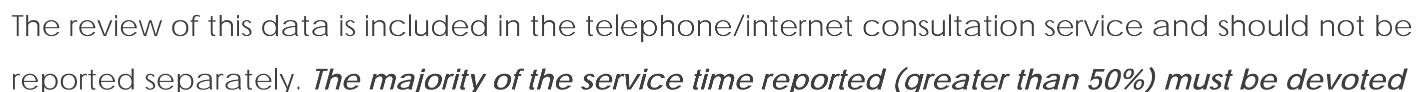
When the telephone/internet consultation leads to an immediate transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, the telephone consultation codes are **not** reported as the work involved would be considered part of the subsequent service.

Again, when the sole purpose of the telephone/internet communication is to arrange a transfer of care or other face-to-face services, these codes are not reported.

The patient for whom the interprofessional telephone/internet consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem.

Review of pertinent medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc., may be required and transmitted electronically by fax or by mail immediately before the telephone/internet consultation or following the consultation.

The review of this data is included in the telephone/internet consultation service and should not be reported separately. ***The majority of the service time reported (greater than 50%) must be devoted***



to the medical consultative verbal/internet discussion. This service should not be reported more than once within a seven-day interval.

The written or verbal request for the telephone/internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request, **and concludes with a verbal opinion report and written report from the consultant to the treating/requesting physician or qualified health care professional.**

Note: Telephone/internet consultations of less than five minutes should not be reported.

Examples (MFM based):

1. The Generalist OB requests a telephone consultation by the MFM Specialist to obtain a clinical opinion on the medical condition of his patient who has a fetus with IUGR and borderline Oligohydramnios. The patient is unable to have a face-to-face consultation with the MFM due to geographical location (3 hours away). All relevant history, laboratory data and imaging studies (ultrasounds) are obtained from the requesting physician. The MFM Specialist provides the requesting physician with management approaches, including the pluses and minuses of each. The Generalist OB does not transfer care of the patient to the MFM's service. The call lasts 25 minutes (CPT 99448).

2. A Generalist OB in the same state requests a telephone consultation by the MFM Physician who specializes in high number of multiples (quads and greater). All relevant history on this patient, laboratory data and imaging studies (ultrasounds) are obtained from the requesting physician and discussed during the call. The MFM Specialist provides the requesting physician with management approaches, including the pluses and minuses of each. The Generalist OB voices that the patient is extremely apprehensive and is willing to relocate near the MFM Specialist. Based on this comprehensive consultation, the decision was made by the Generalist OB to relinquish his/her responsibility to the MFM Specialist who explicitly agrees to accept this responsibility of this patient. Since transfer of care was decided during this initial encounter

and not prior to the call, and there is no initial visit scheduled with consultant MD within next 14 days, the telephone consultation would be reported. The call lasts 40 minutes (CPT 99499).

3. The Generalist OB requests a telephone consultation to discuss abnormal laboratory findings on an obstetrical patient that has never been seen by the MFM Specialist. Due to the nature of the findings, an urgent appointment is scheduled and the patient is seen on the same day. The MFM Specialist performs additional laboratory studies and subsequent ultrasounds. Since the telephone call resulted in an office visit, the telephone consultation would not be reported as a separate encounter. It would be considered part of the E&M Service reported on that same day.

4. The Generalist OB phones the MFM Specialist to discuss the management of a Gestational Diabetic patient. Her laboratory values (glucose levels) are discussed. The MFM is actively co-managing the care of this patient. The patient was seen in the MFM's office three days earlier. The telephone consultation would not be reported since the patient was seen within 14 days.

Caution:

As with any new codes released, we strongly recommend that you contact your local payer to ensure that these codes are reimbursable according to their guidelines and have them added to your existing contracts prior to attempting to bill for these services.

Important:

Since the call is from one provider to another provider, the provider initiating the call MUST have all the necessary insurance information available at the time of the call or be able to provide it within a reasonable timeframe to the consultant. This information needs to include the patient's name, date of birth, Insurance carrier, Plan number, etc. Without this information or a mechanism of obtaining it, a bill for the service could not be generated and submitted to the payer.